Hearing Partners of South Florida

Patient Information Form

Date: _____ Patient Name: _____ DOB: _____

Gender: _____ Social Sec # _____ Marital Status: _____ Age: _____

Street Address: _____Unit/Apt#_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

May we leave a message on your voicemail / text or cell phone to remind you of your appointment? YES / NO

By providing your email address you grant permission for Hearing Partners to send you our monthly newsletter that features educational information, appointment information as well as special promotions.

ARE YOU A SNOWBIRD? YES / NO Address:_____

_____

Out of State Phone: _____

Who is your Primary Care Physician? _____

Name of your community/neighborhood: _____

Who referred you to us today? _____

How did you hear about Hearing Partners?_____

I consent to receive audiological services from Hearing Partners of South Florida. This consent encompasses audiological procedures including, but not limited to, diagnostic testing, rehabilitative treatment, ear wax removal, Lyric insertion and taking of ear mold impressions. I understand that this consent form will be valid and remain in effect as long as I receive audiological care from Hearing Partners of South Florida.

I hereby authorize the following person(s) access to my medical records from Hearing Partners of South Florida (this includes the contents of my medical chart, health condition, hearing device information and financial history):

Relative: _____ Relationship: _____

Relative: _____ Relationship: _____

Caregiver: _____

Other: _____

Other Physician: _____

Signature: _____ Date: _____

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NAME:_____ **DATE:**_____

Do you have any supplemental plan coverage for hearing aid purchases?

☐ Humana ☐ Empire Plan NYS ☐ CIGNA ☐ United Federation of Teachers
☐ Epic ☐ TruHearing ☐ UnitedHealthcare
☐ Amplifon/HearPO ☐ BlueCross BlueShield ☐ Other: _____

List below the medications you currently take or provide a list for our staff to scan into your EMR:

Medication Name	Dosage (mg)	Frequency (how often)	Route (into body)

Please circle any conditions that you currently have or have had in the past:

Heart disease	High blood pressure	Low blood pressure	Vision problems
Shingles	Neurologic Condition	Head Injury	Migraine headaches
Diabetes	Arthritis	Allergies / Sinus	Meningitis / Encephalitis
Cancer	Radiation	Chemotherapy	Kidney disease
Mumps / Measles	Stroke	Aids / HIV / Hepatitis	Bleeding Disorders

Other: _____

Do you have a history of ear surgery / ear drainage / ear pain / fullness in the ears? YES NO

If yes, explain:_____

Do you have a family history of hearing loss? YES NO
Do you currently smoke or use tobacco? YES NO
Have you fallen in the last 12 months? YES NO
Do you have dizziness, vertigo or a loss of balance? YES NO
Do you have any tinnitus (ringing, buzzing or hissing sounds) in your ears? YES NO
Do you have a history of exposure to noise? YES NO
Have you ever worn a hearing aid? YES NO
Previous and/or current occupation? _____
What are two situations in which you have the most difficulty hearing and communicating?

1. _____ 2. _____

How would you rate your hearing on a scale of 1-10 (1 being worst and 10 being best)? Please circle one.

←----------→

1 2 3 4 5 6 7 8 9 10